STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175506	A. BUILDING _____ B. WING _____	C 03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDBE HOME, INC	201 W CRANE ST NORTON, KS 67654

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F 000	INITIAL COMMENTS The following citations represent the findings of the complaint survey into complaint #64051. A revised 2567 was sent to the facility by e-mail on 3/13/13.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: The facility census totaled 70 residents with 7 residents included in the sample. Of those, 3 residents were reviewed for nursing assessment after change in condition. Based on interview and record review the facility failed to consult with the resident's physician immediately after identifying a significant change in resident #1's respiratory status. Findings included: - Review of resident #1's record revealed a nurse's note entry dated 12/12/12 at 9:00 p.m. In the note, staff documented a temperature of 99.5 Fahrenheit. The resident was confused, staff documented the resident's lungs sounds had wheezes noted to upper lobes. The staff administered a Duoneb treatment The staff failed to consult with a physician regarding the change in the resident's respiratory status. Review of the nurses notes dated 12/12/12 at 11:30 p.m. revealed the resident complained of shortness of breath and a productive cough with thick yellow sputum. The resident had diminished sounds to the left and right lower lobes with wheezing noted on expirations. The resident's oxygen saturation was 79% on room air after he/she ambulated. The staff administered a Duoneb treatment and placed the resident on oxygen per nasal cannula. The staff failed to consult with a physician regarding the change in the resident's condition.	F 157		

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F 157	Continued From page 2	F 157		

Review of the nurses notes dated 12-13-12 at 2:00 a.m. revealed staff sent a fax to the physician regarding the resident cough, congestion, wheezing and low grade temperature. Staff failed to call and consult with a physician regarding the resident's condition.

Further review of the Nurses Notes revealed an entry on 12/13/12 at 6:00 a.m. The resident then had a temperature of 101.5 Fahrenheit (above 100 degrees is abnormal) diminished lung sounds, oxygen saturation 94% on 2 liter of oxygen per nasal cannula, pulse 118, blood pressure 175/103 (above 140/80 is considered high), and the resident coughed up blood. The staff called the physician and obtained an order to send the resident to the emergency room for a chest x-ray. The resident was admitted to the hospital for pneumonia.

Interview on 3-6-13 at 4:22 p.m. with Licensed Nurse D revealed that he/she did not notify the doctor that night because the resident ' s wheezing went away and he/she did not seem to have any new changes that needed to be reported to the physician. Licensed nurse D revealed the residents had period of confusion and the wheezing cleared with a DuoNeb aerosol treatment. Nurse D revealed the facility's expectation of the nurses was to notify the physician anytime the resident had a change in condition. Nurse D revealed he/she would have notified the physician if the resident had continued to have wheezing or altered mental status. She revealed the nursing staff faxed the physician concerning non-emergency related issues and confirmed the resident's change in

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F 157	Continued From page 3 lung function and ability to maintain his/her oxygen saturation levels should have required a phone call to the physician, not a fax. Interview on 3-6-13 at 4:40 p.m. interview with Administrative Nurse A revealed after he/she reviewed the nurses notes for 12-12-12 and 12-13-12 the nurses should have paged the doctor and notified him/her of the resident's change of condition instead of sending a fax at 2:00 a.m. and waiting to call the physician until 6 a.m. the resident coughed up blood. Interview on 3-7-13 at 9:55 a.m. with Administrative Nurse A revealed the facility did not have a policy for notifying the physician with a change in the resident's condition. Nurse A revealed the facility's expectation included the nurses would notify the physician by phone, or page for anything that required a change in treatment such as difficulty breathing and signs and symptoms of illness. Interview on 3-7-13 at 10:54 a.m. with Nurse Practitioner E revealed the expectations of his/her office was the facility would call or page the office if the resident had signs and symptoms of illness or significant change in condition for the physician to address. Staff E revealed emergency related concerns should not be faxed to the physician after office hours, faxes were for notification of non-emergency related concerns. The facility failed to identify immediately consult with the resident's physician after identifying a significant change in the resident's respiratory status.	F 157		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309 SS=G	Continued From page 4 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility census totaled 70 residents with 7 residents included in the sample. Of those, 3 residents were reviewed for nursing assessment after change in condition. Based on interview and record review, the facility failed to identify and respond promptly to a significant change in respiratory status after a change in condition for 1 of 3 sampled residents. This failure lead to a delay in resident #1 receiving further respiratory care. The resident received increased breathing treatments, and oxygen began to cough up sputum and blood and required hospitalization. Findings included: - Review of resident's #1's physician's orders sheets signed and dated 2/1/12 revealed a diagnosis of Atrial Fibrillation (an abnormal and irregular heart rhythm). Review resident #1's admission MDS (minimum data set) dated 2/6/12 revealed the resident had a BIMS (brief interview for mental status) score of 14 (cognitively intact), required set up help with meals and remained independent for all ADLs	F 309		

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F 309	Continued From page 5 (activities of daily living). Review of resident #1's quarterly MDS dated 9/15/12 revealed a BIMS score of 15 (cognitively intact) required set up help for meals and dressing, one person assist for dressing, and extensive assist of one staff member for bathing. Review of the resident's Activities of Daily Living CAA (care area assessment) dated 2/6/12 revealed the resident was hard of hearing, wore hearing aids in his/her right ear and glasses. The resident was independent with transfers and ambulation, using rolled walker and staff was to assist as needed. Review of the resident's care plan dated 2/10/12 revealed altered tissue perfusion (the passage of blood through the vessels of a specific organ) related to decreased metabolism alteration in cardiac output (inadequate blood pumped by the heart). The care plan directed the staff to give Duoneb (mist breathing treatment) every 4 hours prn (as needed) for coughing/wheezing. Review of resident #1's record revealed a nurse's note entry dated 12/12/12 at 9:00 p.m. Which documented a temperature of 99.5 degrees Fahrenheit. The note identified the resident was confused and experienced wheezing lung sounds to the upper lobes. The staff administered a Duoneb treatment to address the wheezing but failed to address the temperature. Review of the nurses notes dated 12/12/12 at 11:30 p.m., 2 1/2 hours after the last Duoneb treatment, staff documented the resident complained of shortness of breath, had a	F 309		

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F 309	Continued From page 6	F 309		

productive cough with thick yellow sputum, and oxygen saturation level of 79% (normal is 98 to 100%) on room air after ambulation. Staff assessed the lung sounds and identified a change that included diminished sounds to the left and right lower lobes with wheezing noted on expirations. The staff administered a Duoneb treatment and placed the resident on oxygen per nasal cannula. The staff failed to provide any other respiratory care.

Further review of the Nurses Notes revealed an entry on 12/13/12 at 6:00 a.m. When staff assessed the resident with a temperature of 101.5 degrees Fahrenheit (above 100 degrees is abnormal), oxygen saturation 94% on 2 liter of oxygen per nasal cannula, pulse 118 (60-100 normal), blood pressure 175/103 (above 140/80 is considered high), and the resident coughed up blood. The staff noted the resident had diminished lung sounds throughout the lung fields. At that time, 9 hours after the resident started showing symptoms and had increased need for breathing treatments, oxygen, exhibited confusion, and productive cough with yellow sputum, staff called the physician and obtained an order to send the resident to the emergency room for a chest x-ray. The resident was admitted to the hospital for pneumonia.

Interview on 3-6-13 at 4:22 p.m. with Licensed nurse D revealed the resident normally had periods of confusion and that night the wheezing cleared with a DuoNeb aerosol treatment. Nurse D revealed he/she would have notified the physician if the resident had continued to have wheezing or altered mental status. The nurse failed to identify the failure to address the

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F 309	Continued From page 7 increased temperature, increased breathing treatments, the need for oxygen, shortness of breath and productive cough all signs of significant respiratory change. Interview on 3-7-13 at 10:54 a.m. with Nurse Practitioner E revealed the expectations of his/her office was the facility would call or page the office if the resident had signs and symptoms of illness or significant change in condition for the physician to address. The facility failed to identify and respond to a significant change in the resident's respiratory status including increased breathing treatments, need for oxygen, shortness of breath and productive cough. This delay in prompt treatment lead to the worsening of the resident's respiratory status and a hospitalization.	F 309		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: The facility census totaled 70 residents, with 7	F 325		

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F 325	Continued From page 8	F 325		

residents were sampled of those 3 resident were reviewed for nutrition. Based on observation, interview and record review, the facility failed to provide nutritional supplements as ordered by the physician for 1 of 3 residents. (#3)

Findings included:

- Review of the resident's significant change MDS (minimum data set) dated 9/5/12 revealed a BIMS (brief interview for mental status) score of 10 (moderately impaired) the resident required extensive assist of two staff members for bed mobility, transfers, dressing, toilet use, and personal hygiene. The resident required extensive assist of one staff for personal hygiene and setup help and supervision with meals. The MDS revealed the resident had no broken or lose teeth, his/her height was 64 inches and he/she weighed 140 pounds. The MDS revealed the resident had no significant change in weight.

Review of the resident #3's cognitive loss/dementia CAA (care area assessment) dated 9/10/12 revealed resident was a new admit with a BIMS score of 5 severe cognitive impairment. The resident had a diagnosis of depression (a chronic condition that effects mood and requires medical treatment) and received an antidepressant.

Review of the resident's nutritional status CAA dated 9/10/12 revealed the resident received a mechanical soft diet, received Ensure (high calorie nutritional drink) for nutritional support, and he/she was currently within ideal body weight.

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F 325	Continued From page 9	F 325		

Review of resident #3's quarterly MDS (minimum data set) dated 1/28/13 revealed a BIMS (brief interview for mental status) score of 9 (moderately impaired), required extensive assist of two staff members for bed mobility, transfers, walking, dressing, and toileting. The resident required extensive assist of one staff member for bathing and personal hygiene. The resident required set up help from staff for meals. The MDS revealed the resident's height was 64 inches and he/she weighed 132 pounds. The MDS revealed the resident had no chewing or swallowing problems and had a significant weight change.

Review of the resident's care plan dated 11/13/12 revealed the following problem: alteration in fluid maintenance and nutritional status. The care plan directed the staff to provide the resident a regular diet with texture as tolerated, serve meals in the main dining room or room per his/her choice, remind the resident to eat slowly and to drink plenty of liquids with food, monitor the resident's weight weekly, and give ensure liquid daily for nutritional supplement.

Review of the physician's orders sheet signed and dated 2/27/13 revealed an order for ensure 1 can BID (twice daily) for nutritional supplement.

Review of the resident's dietary notes dated 1/28/13 revealed the resident was to receive a regular diet with ensure 1 can BID.

Review of the resident's weight history revealed the following:

09/07/12 137 pounds

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	175506	A. BUILDING _____ B. WING _____	C 03/12/2013

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F 325	Continued From page 10 10/02/12 136 pounds 11/02/12 132.5 pounds 12/04/12 126 pounds 01/11/12 127.5 pounds 02/01/12 133 pounds 02/26/12 129 pounds Observation on 3-5-13 at 3:00 p.m. revealed direct care staff B took a Mighty Shake(another brand of high calorie nutritional drink) off of the tray that was labeled with the resident's name and served it to the resident. The mighty shake carton was a one serving container that contained 200 calories. The resident drank 100% of the mighty shake. Interview on 3-5-13 at 3:14 p.m. interview with the resident's family member revealed he/she kept a supply of ensure in the resident's room and the staff was supposed to take it out as it was needed and put in the refrigerator and give it to the resident as ordered by physician. Observation on 3-5-13 at 3:15 p.m. of the resident's supply of ensure kept in a drawer in his/her room revealed one can of ensure contained 350 calories per can. Interview on 3-5-13 at 3:00 p.m. with direct care staff B revealed the direct care staff did not have a list of people that received snacks or supplements. The kitchen staff prepared a tray of snack and supplements and labeled each one with the residents name on it. Staff B was unaware the resident should have received a can of ensure bid between meals. Interview on 3-5-13 3:30 p.m. interview with	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175506	A. BUILDING _____ B. WING _____	C 03/12/2013

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ANDBE HOME, INC	201 W CRANE ST NORTON, KS 67654

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F 325	Continued From page 11	F 325		

Dietary staff C revealed the resident received a might shake once daily. Staff C was unaware the resident had a physician's order for ensure 1 can bid. Staff C was unaware that one can of ensure contained 350 calories, he/she confirmed the mighty shake only contained 200 calories. Dietary staff C revealed that he/she obtained the resident's snack and supplement orders from the physician's orders that he/she reviewed weekly for changes.

Interview on 3-6-13 at 2:45 p.m. interview with Administrative staff A confirmed the physician's orders sheets signed and dated 2/27/13 revealed an order for ensure 1 can BID for nutritional supplement. Staff A revealed that kitchen prepared all the physician ordered snacks and labeled them with the resident's name and the direct care staff passed them to the residents. The direct care staff did not have a list of all the resident's that received snacks and what snacks they were ordered to get.

Review of the facility's Nutritional policy last revised 7/27/05 revealed the facility was to prepare and encourage nutritional supplements as the doctor ordered for extra added nutrition and calories.

The facility failed to provide the prescribed nutritional supplement to increase the resident's caloric intake for weight maintenance.